

# SAFETY BULLETIN

## MILITARY SEALIFT COMMAND

Each month ships will receive the Safety at Sea Magazine. The intent of this magazine is to provide additional safety information to vessels. It is also intended to stimulate discussion and safety awareness onboard. The Safety at Sea Magazine will also be accompanied by the "Safety Bulletin" to convey to the fleet important safety current events, safety suggestions, and jobs well done. All references will be added to SMS external library for additional information.



## Line Handling Incident

and stern lines were ordered slackened as heaving commenced on headlines and aft spring lines.

During the shift forward the Master noted that one of the forward spring lines was taut and ordered it slackened. The line was not slackened and suddenly went slack.

A short time later the crewmember operating this winch was found lying on the deck next to the winch platform. He had a severe head injury and his safety helmet was split in half. None of

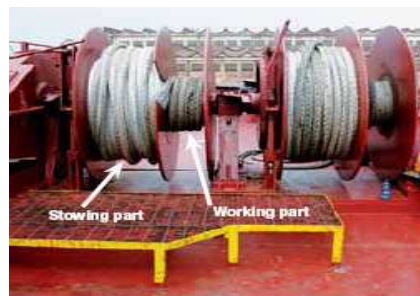
the crew on the forecastle saw what happened as they were all individually tending lines. They did hear what sounded like a mooring line moving rapidly through the air.

The investigation determined that the third mate could not adequately supervise the operation of tending four lines with four men (boatswain, fitter, and 2 ABs )

The second spring line added unnecessary complexity to the forecastle operations. A lack of preparedness and communication

operation starting before the crew on the forecastle were ready.

- The third mate's position during the shift ship operation meant that he did not have a clear view of the spring lines or the crew members operating the spring winch.



Line handling is a dangerous operation. The hundreds of thousands of pounds of force involved when a ship is mooring or unmooring pose a significant hazard to crew fore and aft.

Recently aboard one of our vessels, an individual was injured during a mooring evolution as a line parted and struck him in the leg.

The Australian Transport Safety Board recently released a report of another mooring incident. On April 10, 2006 the *Probo Bear* an Oil/Bulk/Ore ship was shifting forward to facilitate loading next hatch.

The forward spring lines

### LINEHANDLING SAFETY

Line handling can be dangerous during mooring, underway replenishment, fueling, hoisting, towing, and working aloft or over the side. The ability to select, care for, and safely use the lines needed for these tasks requires Sailors to exercise skill and sound judgment. Mishaps could result in loss of life, serious injury, and costly damage to the ship. The first and foremost rule of line handling safety is teamwork. Following orders and looking out for one's shipmates is essential. Line handling safety procedures include:

- Preplanning each operation
- Never stand in the bight of a line or outboard of a line
- Wearing safety shoes with skid-proof soles
- Never straddling or standing on wire ropes or lines
- Never trying to stop a running line by putting a foot on it
- Never stand at the point where a line change direction

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## Safety Snapshot What's wrong with these pictures?



Fig 1



Fig 2



Fig 3

### Safety Myth – Leadership is off the hook for safety.

**Reality:** Safety must be managed by top leaders just as finance and mission are. Leaders must not only “talk the talk,” they must “walk the walk” by committing to safety in both words and actions. Safety leadership functions include resourcing safety, setting the culture, making risk acceptance decisions, communicating safety as a value, and monitoring safety performance.

### Line Handling Incident– continued

- The crew member was struck in the head by a section of mooring line at high speed.

The incorrect use of the winch brake may have led to the formation of fast spinning turns or loops of mooring line.

The kinetic energy built up in the long length of spring line under tension would have been extreme if the winch brake was not controlled correctly. Release of the winch brake under these

conditions would have resulted in high speed recoil, as the energy in the mooring line was released. The winch drum would have started to rotate and then accelerate rapidly. For a time the winch drum would have spun faster than the speed at which the mooring line could run out. This action may have led to the formation of slack turns or loops of mooring line which would have been rotating with the drum. It was

probably one of these loops of mooring line that struck the AB in the head causing his fatal injuries.

The full report is available at: [http://www.atsb.gov.au/publications/investigation\\_reports/2006/MAIR/pdf/mair230\\_001.pdf](http://www.atsb.gov.au/publications/investigation_reports/2006/MAIR/pdf/mair230_001.pdf)

Incident	Lesson Learned
Mariner was dogging the fidley door on 01 level and the dogs were loose. Mariner's hand got caught between door and dog.	Ensure that dogs are properly maintained to appropriate tightness. Pay attention to body placement when accomplishing tasks.
Mariner was moving cover plates (200-250 lbs) from one location to another and afterwards noticed a pain in the lower back.	Always use proper lifting techniques and utilize more than one person to make lifts for heavy loads
Injured while grinding off nut & bolt off valve, Part of grinding wheel broke off and stuck in hand.	No matter the size of grinder always keep two hands on grinder and keep other body parts clear of work area
Buckets of oil were being lowered from main deck to lower level of engine room by line. Line slipped and bucket struck individual below in head	Always keep lift area clear of personnel and properly secure loads prior to lifting.
While pulling garbage from the dumbwaiter the ship rolled and door unlatched and door hit mariner in head.	Always properly secure all doors, hatches, covers at sea, if not vessel motion may put door in motion
While cutting line to secure items in cabin mariner accidentally cut finger with pocket knife.	Ensure proper cutting techniques and ensure knives are maintained sharp to prevent snags when cutting.
Equipment fell on Mariner's foot while it was moved	Always wear steel toes to protect feet from crushing injuries
Mariner woke with back pain after carrying chemicals from chemical locker (40-60 lbs) to lower decks the previous day.	Always use proper lifting techniques and utilize more than one person to make lifts for heavy loads





<b>Incident</b>	<b>Lesson Learned</b>
During inspection of gasoline jettison rack, mariner lifted gasoline canister and experienced shooting pain in back.	Always use proper lifting techniques and move as close to load as possible
While shifting the port side hawse pipe cover in preparation for preservation, this mariner slipped on wet (ice) and strained leg.	Ensure work areas are safe prior to commencing work
Mariner jumped down from the feed water pipe a adjusting overboard discharge valve & twisted ankle	Use proper climbing access routes (ladders) and techniques (No jumping)
Mariner caught foreign body in eye while operating grinder and wearing safety glasses	Consider using face shield in addition to safety glasses for grinder
Ships force pumped Fryquel(fuel) into hydraulic ram cylinder for maintenance. When hose was disconnected it sprayed into mariner's eyes.	When working with hydraulic systems consider use of safety glasses, goggles or face shield dependent upon task.  When disconnecting hoses previously under pressure have other personnel stand clear.
Walking up ladder from second deck to main deck mariner hit head on cross beam	Ensure that low overheads are appropriately marked and if feasible guarded against impact.  Ensure proper use of herd hats.
An improper type inlet air paper/fiber filter element was installed in HVAC system When the heater was energized; the paper element began to char, causing the smoke and activating a smoke detector. The fire alarm and the engine room monitoring systems sounded, causing the chief engineer to report to the engine room then subsequently report the fire alarm as indicated on the engine room monitoring panel. The gangway is equipped with a similar monitoring panel, but there is no audible alarm for the panel installed at the gangway. The alarm light was flashing, but it did not catch the attention of the deck watch stander.	All filter elements on vessel were inspected and any unauthorized paper elements were removed and discarded.  Ensure that all watch standers understand the limitations of fire detection system.
Minor Class A fire occurred while conducting maintenance on UNREP winch. Heat lamp used to dry out winch motor and was too close to tarp covering winch causing it to catch on fire. Fire was put out in less than a minute. Damage incurred: scorched paint on winch motor.	Ensure that possible ignition and fuel sources have adequate separation
55 gal drum of AFFF slid off pallet rolling down a ladder and injuring 36 yr old contract worker (broken lower right leg).	Always keep lift area clear of personnel and properly secure loads prior to lifting
While mooring outboard of another vessel, starboard bow of one ship came up hard against the port bow of moored vessel causing damage to roller fairlead.	Ensure bow thruster characteristics and delay times are communicated to Pilot during Master Pilot exchange
Mariner was cleaning space and when individual removed goggles, Dust got into his eyes. Mariner immediately irrigated eyes with emergency eyewash station	Ensure all personnel are able to identify locations of emergency eyewash stations

## **Safety Suggestions From the fleet**

"Forklift procedures should be developed in SMS system." **MHE procedures are in development and should be out to the fleet for comment by spring 2007.**

"Procedure for Use of Spiders should be developed in SMS system" Procedures for Spiders, Boatswain's chair and **Stages are in development. Fall Protection**

**standards are being coordinated with NAVSAFECEN.**

"Replacement showers need to be marine grade " **Proper Trans Alt procedures should be followed and Port Engineers are reminded to review procedure.**

Have Suggestions? Let us hear about them.

SMS Procedures soon in draft:

MSO and SUPPO Turnover, MHE, Hot Work with ordinance aboard, Electrical Safety

Provide your comments and suggestions on procedures to email addresses on back of notice

To view draft procedures go to:

<http://basic.share.expertman.com/imsshare/>

User: ismguest  
Password: ismguest

# MILITARY SEALIFT COMMAND

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## This date in history

January 9, 1918 - Establishment of Naval Overseas Transport Service to carry cargo during World War I

January 13, 1840, The steamship *Lexington* was carrying 143 passengers and 150 bales of cotton from Manhattan to Stonington CT and a fire began in the evening during the transit. The crew was unable to extinguish with hand driven fire pump. The crew was also unable to secure the boilers and take way off to launch lifeboats. Vessel grounded 2 miles from shore. 139 persons died as a result of fire, hypothermia or drowning.

January 28, 1962 - USS Cook (APD-130) rescues 25 survivors from after section of Panamanian tanker, SS *Stanvac Sumatra*, which broke in two in the South China Sea

January 30, 1945 *Wilhelm Gustloff* sinks carrying refugees from Germany, approximately 7000 persons die.

January 31, 1953 The *Princess Victoria* was one of the earliest Roll On Roll Off (RORO) ferries which served the route from Scotland to north Ireland. During heavy weather, stern doors were damaged and allowed ingress of water to car deck. Vessel became unstable and sank with loss of 132 people.

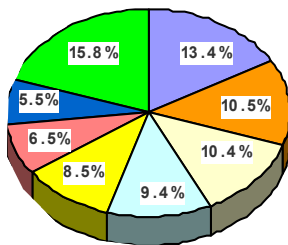
### Safety Recognition

We would like to recognize the following for their continued efforts towards improving the Safety Program:

**Dale Krabbenschmidt - Sean Tortora - Ray Blanchet - Frank Ridge  
John Pope - Rodger Lagrone - Mike Price - Chris Cook - Tim Delp**

## Port State Control

### Top PSC Findings and how to avoid detention



A recent report from Germanischer Lloyd on top findings from port state control visits revealed the types of findings and percentage of occurrence in the graph above.

Among the findings items of particular concern are:

- Charts and publications were not corrected.

- A system should be in place to ensure that all publications on board can be easily updated.

- Hydrant valves need to be easy to turn. Hoses must not leak when used for testing and should be properly fastened to the couplings.

- Fire hose boxes must be complete with hose, nozzle and spanner.

- Fire dampers have to be working properly. The handles must be easy to move and the inscription has to show the name of the closable compartment and the position of the handle for "open" and "closed". The dampers have to be conspicuously marked. If the closures work with a flap, it has to be properly hinged and move easily. Rubber packings need to be in good condition

and toggles greased and capable of tightly closing the flap.

- Fire doors have to close properly and must not be obstructed. Automatic closing devices need to be capable of closing doors completely. Hold-back hooks are not permitted.
- Oil in the engine room represents a possible fire hazard – and a potential safety hazard for the crew if oil makes the floor plates or decks slippery. Engine rooms should be reasonably clean.
- Bilges should not contain excessive amounts of residues but should be emptied to holding tanks or ashore, as required.
- Ventilators, air pipes and other closable pipe openings need to be in good working order, close properly and have no leaks. The positions of any handles have to be marked for "open" and "shut".

The full report is available at: [www.gl-group.com](http://www.gl-group.com)

Answers for Page 2: Fig 1: When line handling jewelry and watches should be removed. Also consider use of Safety Glasses and hard hat. Fig 2: Too close to check, if something goes wrong body parts will be pulled right through check. Fig 3: Good use of PPE but individuals engaged in line handling need to focus on task at hand and not joke around.